Carolina Ear & Hearing Clinic, PC ★

MEDICAL RECORDS RELEASE AUTHORIZATION

Upon presentation of this authorization you are requested to provide the records outlined below to:

Recipient		
Person/Company		
Address		
City	State	Zip
Phone	Fax	
Clinic/Hospital Name		
Patient Name		DOB

Dates of Service (Check One and Complete Dates of Service if Required)

☐ Please provide a complete copy of my file for all dates of service
☐ Please provide a complete copy of my file for service dates:

Records to be Released (45 CFR § 164.508(c)(1)(i))

☐ All records	☐ History & Physical	☐ Consultation Reports
☐ Emergency Room Record	☐ Operative Report	☐ Discharge Summary
☐ Lab/Pathology Reports	☐ Radiology Reports/Images	☐ Other

Purpose for Disclosure

☐ Referring Physician	☐ Patient Request	☐ Disability (we do not participate)
☐ Claims Processing	☐ Legal Review	☐ Other

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, communicable disease, including HIV and AIDs (45 CFR § 164.508(c)(2)(iii)).

☐ I understand that there is a minimum charge of $10 for all records released from this office.

☐ I understand that there is a two (2) week turn around for completion of records requests.

This authorization will expire ninety (90) days from the date of my signature, or receipt of this signed document in our office, unless I revoke the authorization, in writing, prior to that time.

Print Name of Patient/
Authorized Representative: _____

Signature of Patient/
Authorized Representative: _____

Date: